

State of Iowa

DEPARTMENT OF ADMINISTRATIVE SERVICES – HUMAN RESOURCES ENTERPRISE**DONATED LEAVE FOR CATASTROPHIC ILLNESS****IMMEDIATE FAMILY MEMBER****TRACKING**

Department: _____

Pay Period Date: FROM _____ TO _____

RECIPIENT OF ANNUAL LEAVE (VACATION) DONATIONS:

NAME: _____

PAYROLL #: _____

SOCIAL SECURITY #: _____

BI-WEEKLY PAY: _____ HOURLY PAY: _____

TOTAL ANNUAL LEAVE (VACATION) RECEIVED: _____

OF HOURS _____ X HOURLY PAY: _____ = \$ _____

EMPLOYEES DONATING ANNUAL LEAVE (VACATION):

NAME	NUMBER OF HOURS DONATED	TYPE OF HOURS DONATED	\$ AMOUNT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

